



NACCHO

National Aboriginal Community
Controlled Health Organisation
Aboriginal health in Aboriginal hands

www.naccho.org.au

**Clinical practice
guidelines for the
prevention, early
detection and
management of
colorectal cancer**

**Submission of feedback
to the Cancer Council**

May 2023

ABOUT NACCHO

NACCHO is the national peak body representing 145 Aboriginal Community Controlled Health Organisations (ACCHOs) and assisting a number of other community-controlled organisations.

The first Aboriginal medical service was established at Redfern in 1971 as a response to the urgent need to provide decent, accessible health services for the largely medically uninsured Aboriginal population of Redfern. The mainstream healthcare system was not meeting the needs of Community. So it was, that over fifty years ago, Aboriginal people took control and designed and delivered their own model of health care. Similar Aboriginal medical services quickly sprung up around the country. In 1974, a national representative body was formed to represent these Aboriginal medical services at the national level. This has grown into what NACCHO is today. All this predated Medibank in 1975.

NACCHO liaises with its membership (including the eight state/territory affiliates organisations), governments and other organisations on Aboriginal and Torres Strait Islander health and wellbeing policy and planning issues, and leads advocacy relating to health service delivery, health information, research, public health, health financing and health programs.

NACCHO is assisted in its leadership of the sector by the eight affiliate organisations across all States and Territories of Australia. Affiliates lead jurisdictional cooperation between the ACCHOs, government and the public health sector, working to improve the responsiveness, quality and access to culturally appropriate public health services. They provide input to national policy informed by their grass-roots connectivity to community through the ACCHOs.

ACCHOs range from large multi-functional services employing several medical practitioners and providing a wide range of comprehensive primary care and allied health services, to small services which rely on Aboriginal health practitioners and/or nurses to provide the bulk of primary health care services. Our 145 members provide services from about 550 clinics. Our sector provides over 3.1 million episodes of care per year for over 410,000 people across Australia, which includes about one million episodes of care in very remote regions.

ACCHOs contribute to improving Aboriginal and Torres Strait Islander health and wellbeing through the provision of comprehensive primary health care, integrating and coordinating care and services that can include home and site visits; medical, public health and health promotion services; allied health; nursing services; assistance with making appointments and transport; help accessing childcare or dealing with the justice system; drug and alcohol services; and help with income support. Our services build ongoing relationships with Community members, with continuity of care so that chronic conditions are managed, and preventative health care is targeted. Through local engagement and a proven service delivery model, our clients 'stick'. Clearly, the cultural safety with which we deliver our services is a key factor of our success.

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Recommendations

NACCHO recommends ensuring all components of the document are clearly explained in language that is accessible to all, with minimal technical terminology.

NACCHO recommends extending the intended audience to all members of the healthcare team, including Aboriginal Health Practitioners and Aboriginal Health Workers.

NACCHO recommends the inclusion of additional information on involvement of Aboriginal and Torres Strait Islander consumers in the development of the draft chapters.

NACCHO recommends specific guidance on how healthcare professionals can ensure equity in colorectal cancer screening participation.

NACCHO recommends focusing on the importance of early detection, improving participation rates in screening, access to early colonoscopy in the public system and ensuring there are culturally safe and appropriate pathways and communication materials to raise awareness about bowel cancer for Aboriginal and Torres Strait Islander people.

NACCHO recommends a review into the usability of the National Cancer Screening Register, including adequate consultation with the community-controlled sector to ensure all barriers to using the register are addressed and removed.

NACCHO recommends immediate investigation and consideration into the feasibility of single test screening as a method to reducing barriers to screening for Aboriginal and Torres Strait Islander people.

NACCHO recommends exploring pragmatic approaches to encouraging participation in the NBCSP for areas affected by the hot zone policy.

NACCHO recommends sensitivity and cultural safety considerations employed when discussing family history and risk with Aboriginal and Torres Strait Islander people.

NACCHO recommends updating the draft chapters to reflect the specific amendments listed in Appendix A.

Introduction

NACCHO welcomes the opportunity to provide feedback on the draft chapter updates for the *Clinical practice guidelines for the prevention, early detection and management of colorectal cancer*. Cancer is now the leading cause of death among Aboriginal and Torres Strait Islander people, having overtaken circulatory diseases in 2017,¹ with colorectal cancer (CRC) being the third-most diagnosed cancer after lung and breast cancers.²

Bowel cancer is a preventable cancer, and if detected early, it can be successfully treated in up to 90% of cases. Data shows Aboriginal and Torres Strait Islander people aged 50-74 participate in the National Bowel Cancer Screening Program (NBCSP) at much lower rates than other Australians (35.2% versus 45.5%).³ Concerningly, for Aboriginal and Torres Strait Islander people who do participate, they experience a higher screening positivity rate (10% versus 7%), lower diagnostic assessment follow up rate (51% versus 62%) and a longer median time between a positive screen and diagnostic assessment (64 days versus 49 days) compared to other Australians.³ These factors all contribute to Aboriginal and Torres Strait Islander people diagnosed with bowel cancer experiencing a much lower five-

year survival rate (58% compared to 67% for other Australians) and an increased likelihood of dying from bowel cancer at a younger age.²

NACCHO has chosen to provide both general and specific feedback on the draft chapters. Feedback has been categorised as:

- General feedback
- Targeted feedback – with a focus on:
 - population screening
 - risk and screening based on family history
- Specific amendments.

NACCHO's submission is based around the principles of the *National Agreement on Closing the Gap*. NACCHO has provided advice on several consultations in recent years around CRC screening and the NBCSP.

National Agreement on Closing the Gap

In July 2020 the Australian Government, all state and territory governments, and the Coalition of Peaks signed the *National Agreement on Closing the Gap* (National Agreement). The reforms and targets outlined in the National Agreement seek to overcome the inequality experienced by Aboriginal and Torres Strait Islander people and achieve life outcomes equal to all Australians. All governments have committed to the implementation of the National Agreement's four Priority Reform Areas, which seek to bring about structural change to affect ways in which governments work with Aboriginal and Torres Strait Islander organisations, communities, and individuals. The four Priority Reforms are:

Priority Reform Area 1 – Formal partnerships and shared decision-making

This Priority Reform commits to building and strengthening structures that empower Aboriginal and Torres Strait Islander people to share decision-making authority with governments to accelerate policy and place-based progress against Closing the Gap.

Priority Reform Area 2 – Building the community-controlled sector

This Priority Reform commits to building Aboriginal and Torres Strait Islander community-controlled sectors to deliver services to support Closing the Gap. In recognition that Aboriginal and Torres Strait Islander community-controlled services are better for Aboriginal and Torres Strait Islander people, achieve better results, employ more Aboriginal and Torres Strait Islander people, and are often preferred over mainstream services.

Priority Reform Area 3 – Transformation of mainstream institutions

This Priority Reform commits to systemic and structural transformation of mainstream government organisations to improve to identify and eliminate racism, embed and practice cultural safety, deliver services in partnership with Aboriginal and Torres Strait Islander people, support truth telling about agencies' history with Aboriginal and Torres Strait Islander people, and engage fully and transparently with Aboriginal and Torres Strait Islander people when programs are being changed.

Priority Reform 4 – Sharing data and information to support decision making

This Priority Reform commits to shared access to location-specific data and information (data sovereignty) to inform local-decision making and support Aboriginal and Torres Strait Islander

communities and organisations to support the achievement of the first three Priority Reforms.

General feedback

Language

NACCHO notes and commends the inclusion of the plain language introductions to the draft chapters. To increase the reach of the guideline to all healthcare workers, minimal technical terminology should be employed across all components. The use of complex language reinforces inequities by ensuring only a select few can truly understand the evidence.

NACCHO recommends ensuring all components of the document are clearly explained, with minimal technical terminology.

Intended audience

NACCHO notes doctors are referred to as the intended, primary audience of the guideline. However, acknowledging the contribution to screening of the broader healthcare team, including Aboriginal Health Practitioners and Aboriginal Health Workers, is essential.

NACCHO recommends extending the intended audience to capture all members of the healthcare team, including Aboriginal Health Practitioners and Aboriginal Health Workers.

Consumer engagement

NACCHO is aware that the Cancer Council sought Aboriginal and Torres Strait Islander involvement in the chapter reviews. While Appendix 1 details much of the guideline development process, NACCHO is interested in gaining more insight into how Aboriginal and Torres Strait Islander consumers were engaged and consulted in developing the draft chapters.

NACCHO recommends the inclusion of additional information on processes undertaken to optimise involvement of Aboriginal and Torres Strait Islander consumers and experts in the development of the draft chapters.

Ensuring equity

NACCHO acknowledges the efforts to highlight the importance of ensuring equitable access to, and participation in, CRC screening. Equity is an essential aspect of any population-based screening program. Specific guidance regarding how healthcare professionals, associations and other key stakeholders might ensure equity would be helpful. This guidance would be particularly beneficial in the context of a proposed reduction in the screening age, given this is likely to exacerbate inequities faced by Aboriginal and Torres Strait Islander peoples and other disadvantaged population groups.

NACCHO recommends specific guidance on how healthcare professionals can ensure equity in CRC screening participation.

Population screening

Reductions in the screening age

NACCHO acknowledges the modelling study by Lew et al.⁴ found that reductions in the screening start age may result in cost-effective improvements in cancer detection and reductions in CRC incidence and mortality among Aboriginal and Torres Strait Islander peoples. However, the modelled increased participation rates for Aboriginal and Torres Strait Islander people (equal to those observed across the general population) would be associated with even greater reductions in CRC incidence and mortality,

with even greater cost-effectiveness margins. Increased participation rates would achieve these reductions without a substantial change in the incremental number needed to colonoscope.⁴

There is little evidence to support the acceptability of a reduction in the CRC screening start age among Aboriginal and Torres Strait Islander people. Conversely, culturally informed, place-based approaches to increase participation rates, such as the National Indigenous Bowel Screening Pilot,⁵ (also known as the Alternative Access Model) have been shown to be effective with adequate support and funding. All initiatives to increase participation must consider the local and cultural contexts in which they are taking place. The recent national roll-out of the Alternative Access Model to primary care providers, including ACCHOs, is an important step in increasing screening participation for eligible Aboriginal and Torres Strait Islander people.

There is scope to strengthen participation in the NBCSP by optimising existing national systems and processes and implementing key learnings from trials and implementation in place must be trialled and tested on the ground for usability and must promote easy access. For example, NACCHO has received feedback from many ACCHOs that ordering and issuing screening kits through the National Cancer Screening Register is challenging. This presents a significant barrier to participating in the NBCSP.

NACCHO recommends focusing on the importance of early detection, improving participation rates in screening, access to early colonoscopy in the public system and ensuring there are culturally appropriate pathways and communication materials to raise awareness about bowel cancer for Aboriginal and Torres Strait Islander people.

NACCHO recommends a review into the usability of the National Cancer Screening Register, including adequate consultation with the community-controlled sector to ensure all barriers to using the register are addressed and removed.

Single test screening

Single immunochemical faecal occult blood testing (iFOBT) is utilised quite broadly as a CRC screening modality in other countries, as outlined in the update. There is some evidence emerging that single test screening is preferred and may result in higher participation rates.⁶ As two-test screening remains the preferred protocol in this update, explanation of the rationale for this continuance should be strengthened. NACCHO strongly advocates for the exploration of single-test screening as a means of improving participation rates, especially given the barriers faced by, and potential benefits to, Aboriginal and Torres Strait Islander peoples.

NACCHO recommends immediate investigation and consideration into the feasibility of single test screening as a method to reducing barriers to screening for Aboriginal and Torres Strait Islander people.

Hot zone approaches

While the importance of the *hot zone policy* is acknowledged, it is known that individuals and communities impacted by this policy are more likely to be living in rural or remote areas, with a higher proportion of Aboriginal and Torres Strait Islander people affected.⁷ There are multiple communities across northern and central Australia classified as a hot zone all year round, and many more affected for more than six months each year. Given this, careful consideration and nuancing of the messaging and options to promote around participation in the NBCSP is required to enhance screening participation whilst maintaining viability of samples. Targeted health-promoting initiatives run by the community-controlled sector are more likely to be effective in such *hot zones*. These initiatives should

be explored further, and options considered for supporting communities that might otherwise be disadvantaged by the *hot zone policy*.⁷

NACCHO recommends exploring pragmatic approaches to encouraging participation in the NBCSP for areas affected by the hot zone policy.

Risk and screening based on family history

Given the pervasive impacts of colonisation, racism and intergenerational trauma,⁸ cultural safety should be emphasised as a key aspect of asking about and assessing CRC risk based on family history among Aboriginal and Torres Strait Islander people.

As this chapter is based on risk and risk categorisation, definitions of each risk category must be clearly articulated.

As noted in both chapters, there is minimal evidence regarding Aboriginal and Torres Strait Islander people and CRC risk and outcomes. As such, consideration should be given to further highlighting the uncertainties in stratifying individual CRC risk among such populations. This is particularly relevant as previous studies have found that a family history of cancer was identified as a barrier to participating in CRC screening for Aboriginal and Torres Strait Islander people.^{9,10} These studies further highlight the importance of education by, and engagement with, trusted healthcare professionals.

NACCHO recommends sensitivity and cultural safety employed when discussing family history and risk with Aboriginal and Torres Strait Islander people.

Specific amendments

To reflect the commitment to equity, it is important that the language and framing of the draft chapters consistently demonstrates a culturally appropriate, person-centred, strengths-based approach. In Appendix A, NACCHO has outlined specific language and content amendments suggested for consideration to strengthen the cultural appropriateness and clarity of the draft chapters.

Please note that these changes may not be required if the Working Party elects to simplify the language throughout the draft documents to improve accessibility and make it more reader friendly. NACCHO would welcome the opportunity to discuss these proposed amendments in more detail.

NACCHO recommends updating the draft chapters to reflect the amendments listed in Appendix A.

Conclusion

To close the gap, there is an urgent need for tangible improvements in the cancer outcomes for Aboriginal and Torres Strait Islander people. There is opportunity to recognise and build on and scale the existing work and successes of the Aboriginal Community Controlled Health Sector to achieve such change.

Initiatives must be firmly aligned with the Four Priority Reform Areas of the National Agreement on Closing the Gap, led by Aboriginal and Torres Strait Islander people. Equity must be at the centre of all initiatives.

The draft chapters could be strengthened to better address the needs of Aboriginal and Torres Strait Islander people. Ongoing efforts to ensure meaningful involvement of Aboriginal and Torres Strait Islander people at all stages of future guideline development will strengthen future guidelines. Without such involvement and change there is a risk that current and future guidelines will continue

to exacerbate the inequities faced by Aboriginal and Torres Strait Islander people and other priority population groups.

Aboriginal health belongs in Aboriginal hands.

Reference list

1. Australian Institute of Health and Welfare. Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2018. Australian Burden of Disease Study series no. 26. Cat. no. BOD 32. Canberra: Australian Government; 2022. Available from: <https://www.aihw.gov.au/reports/burden-of-disease/illness-death-indigenous-2018/summary>.
2. Australian Institute of Health and Welfare. Cancer in Aboriginal & Torres Strait Islander people of Australia. [Internet]. Canberra: Australian Government; 2018. Available from: [Cancer in Aboriginal & Torres Strait Islander people of Australia, About - Australian Institute of Health and Welfare \(aihw.gov.au\)](https://www.aihw.gov.au/reports/cancer/cancer-in-aboriginal-and-torres-strait-islander-people-of-australia/about)
3. Australian Institute of Health and Welfare. Australian Institute of Health and Welfare 2022. National Bowel Cancer Screening Program: monitoring report 2022. Cat. no. CAN 148. Canberra: AIHW. Available from: [National Bowel Cancer Screening Program monitoring report 2022 \(aihw.gov.au\)](https://www.aihw.gov.au/reports/cancer/national-bowel-cancer-screening-program-monitoring-report-2022)
4. Lew JB, Feletto E, Worthington J, Roder D, Canuto K, Miller C, D'Onise K, Canfell K. The potential for tailored screening to reduce bowel cancer mortality for Aboriginal and Torres Strait Islander peoples in Australia: Modelling study. *Journal of Cancer Policy*. 2022 Jun 1;32:100325. Available from: [The potential for tailored screening to reduce bowel cancer mortality for Aboriginal and Torres Strait Islander peoples in Australia: Modelling study | Elsevier Enhanced Reader](https://www.elsevier.com/locate/jocp)
5. Menzies School of Health Research, National Bowel Cancer Screening Program. National Indigenous Bowel Screening Pilot: Final Report [Internet]. 2020. Available from: [National Indigenous Bowel Screening Pilot final report, October 2020 \(health.gov.au\)](https://www.health.gov.au/resources/publications/national-indigenous-bowel-screening-pilot-final-report-october-2020)
6. Schreuders EH, Ruco A, Rabeneck L, Schoen RE, Sung JJ, Young GP, Kuipers EJ. Colorectal cancer screening: a global overview of existing programmes. *Gut*. 2015 Oct 1;64(10):1637-49. Available from: [untitled \(researchgate.net\)](https://www.researchgate.net/publication/275111110)
7. Worthington J, Lew JB, He E, Broun K, D'Onise K, Grogan P, Canfell K, Feletto E. The 'hot zone policy' for colorectal cancer screening presents unique risks and opportunities for rural Australia. *Australian Journal of Rural Health*. 2023 Mar 13. Available from: [The 'hot zone policy' for colorectal cancer screening presents unique risks and opportunities for rural Australia - Worthington - Australian Journal of Rural Health - Wiley Online Library](https://onlinelibrary.wiley.com/doi/10.1111/ajrh.12544)
8. Paradies Y. Colonisation, racism and indigenous health. *Journal of Population Research*. 2016 Mar;33(1):83-96. Available from: [Colonisation, racism and indigenous health | SpringerLink](https://www.springerlink.com)
9. Christou A, Thompson SC. Colorectal cancer screening knowledge, attitudes and behavioural intention among Indigenous Western Australians. *BMC Public Health*. 2012 Dec;12:1-6. Available from: [Colorectal cancer screening knowledge, attitudes and behavioural intention among Indigenous Western Australians | SpringerLink](https://www.springerlink.com)
10. Javanparast S, Ward PR, Carter SM, Wilson CJ. Barriers to and facilitators of colorectal cancer screening in different population subgroups in Adelaide, South Australia. *Medical Journal of Australia*. 2012 May;196(8):521-3. Available from: [196_08_070512.book\(jav10701_fm.fm\) \(mja.com.au\)](https://www.mja.com.au)

Appendix A: Specific language and content amendments

1b. Population Screening Chapter		
Section	Page number	Suggested amendment
Plain language summary	10	Suggest the guideline target a broader audience, not just focus on doctors. For example, primary health care workforce including nurse practitioners, Aboriginal health workers (AHW) and Aboriginal health practitioners (AHP). Change doctors to clinicians to look after people before they get bowel cancer.
Plain language summary – who should have regular screening for bowel cancer?	11	Consider including sentence why asymptomatic people are only eligible i.e., that people with bowel cancer symptoms should discuss their symptoms with a GP to ensure appropriate investigation, follow up and support.
Plain language summary – where to find information about bowel cancer and bowel cancer treatment?	11	Suggest including references to resources for Aboriginal and Torres Strait Islander people and Culturally and Linguistically Diverse populations.
1.2 Intended users	12	Update the Plain language summary with the language in this paragraph as it's easier to read.
1.3 Target populations	12	Remove the reference to Aboriginal and/or Torres Strait Islander people in the bullet points. Consider simplifying the target population i.e. People 45-74 without symptoms of colorectal cancer.
1.3 Target populations	12	Update sentence to 'people <i>living</i> with disabilities'.
1.7 Guideline development process	14	Confirm who the Aboriginal and Torres Strait Islander representation in the Working Party refers to. If it is Dr Kate Armstrong, remove reference as it may not accurately reflect contribution or level of involvement of Aboriginal and Torres Strait Islander people in the working party.
1.7 Guideline development process – clinical questions	14	Separate the clinical questions so they are clearly articulated.
1.8 Scheduled review of these guidelines	18	Suggest including a specific revision date for the clinical guidelines i.e., before 2033.
2. Summary of recommendations - colorectal cancer screening benefit	19	Every recommendation across both chapters has a weak strength rating. Consider addressing and defining the strength rating in both chapters. Define the implications of a weak rating and outline what recommendations could inform future research priorities and directions.
2. Summary of recommendations – practice point 13	21	Amend wording at the end of the paragraph to clarify intention of complete intubation (i.e. does the current wording suggest not complete intubation or complete intubation constitutes high quality) and incorporate plain language information about bowel preparation and intubation.
2. Summary of recommendations – practice point 14	21	Review and consider removing the reference to ' <i>carries the risk of a misleading negative test result because of low levels of bleeding from a cancer or adenoma</i> ' because this would lead to bowel cancer

		screening being irrelevant altogether.
2. Summary of recommendations – practice point 15	21	Separate this point into two sentences i.e., place a full stop at the end of psychological harm and a new sentence with the statement that there is no evidence that prognosis is worsened within 120 days if cancer is present. Consider if there is scope to include advice for health practitioners on how to support clients/ any action that can be taken where there is a long wait time for a colonoscopy.
2. Summary of recommendations- practice point 16	22	Amend sentence to ‘GP or <i>clinic</i> endorsement letters in advance of receiving a test kit, the use of <i>recall and</i> reminder systems’.
2. Summary of recommendations – practice point 18	22	This practice point is unclear. Perhaps separate the preferred method of screening and purpose of colonoscopy into two practice points
2. Summary of recommendations- practice point 19	22	Amend sentence to ‘ongoing efforts to identify methods to improve ‘ <i>colorectal cancer</i> ’ screening participation’.
2. Summary of recommendations- practice point 22	23	Remove the reference to ‘ <i>and increase</i> ’ participation in the last sentence.
3.1.1 Population colorectal cancer screening	25	Amend the dot point or add a footnote to the ‘ <i>Distribution of invitations and iFOBT kits primarily by mail</i> ’ to acknowledge the Alternative Access Pathway has been scaled up to increase participation rates of Aboriginal and Torres Strait Islander people. Include referral to the Alternative Access Pathway section 3.1.3.
3.1.1 Population colorectal cancer screening	25	Include additional figure of Alternative Access Pathway to compare against Figure 1. NBCSP population screening pathway

		<div style="border: 1px solid black; padding: 10px;"> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;">Mail-out Model</div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;">Alternative Access Model</div> </div> <p>The diagram illustrates two models for kit distribution and return. The Mail-out Model (top) shows a linear process: 1. Access: Healthcare Provider registers for access to the NCSR HCP Portal. 2. Bulk order kits: Healthcare Provider orders the free test kits in bulk through the NCSR HCP Portal. 3. Issue kit: Healthcare Provider submits Issue kit form through the NCSR HCP Portal. Healthcare Provider hands kit with PD form to participant. 4. Kit return: Kit and PD form mailed to participant by the NCSR. Participant returns kit via mail. 5. Results: Results sent to the participant and nominated Healthcare Provider. The Alternative Access Model (bottom) shows: 1. Access: Healthcare Provider registers for access to the NCSR HCP Portal. 2. Bulk order kits: Healthcare Provider orders the free test kits in bulk through the NCSR HCP Portal. 3. Issue kit: Healthcare Provider submits Issue kit form through the NCSR HCP Portal. Healthcare Provider hands kit with PD form to participant. 4. Kit return: Participant returns kit via mail or to the Healthcare Provider to then mail. 5. Results: Results sent to the participant and nominated Healthcare Provider.</p>
5.7 Evidence to decision – iv. Resources and other consideration	53	Amend wording to clarify intention of complete intubation (i.e., does the current wording suggest not complete intubation or complete intubation constitutes high quality) and incorporate plain language information about bowel preparation and intubation.
6. Preferences for colorectal cancer	54	Explicitly reference evidence to justify the two-sample immunochemical faecal occult blood test

screening modalities		(iFOBT) as opposed to one-sample test. International programs offer evidence of one sample colorectal screening programs with iFOBT and have significantly higher participation rates.
6. Preferences for colorectal cancer screening modalities	54	Amend the sentence that there is no clear preference for sample number. If there is evidence that patient preferences showed an indicative preference for a single sample test and some evidence of a higher uptake in screening for a single sample, this suggests one sample is preferred. Individuals will naturally prefer taking one sample instead of two.
7. Participation in the population screening for colorectal cancer	55	Update language in the first paragraph to capture all health practitioners can facilitate participation including nurses, AHW and AHP . Explicitly identify lifestyle factors that are associated with non-participation in NBCSP.
7. Participation in the population screening for colorectal cancer	56	Amend the sentence to include clinic letters/reminders encouraging participation: 'specifically in primary care, this may include GP <i>or clinic</i> endorsement letters in advance of receiving an invitation to participate in population screening, the use of GP <i>or clinic</i> reminders to encourage discussions of CRC screening'.
7.1 recommendations and practice points - practice point 18	56	This practice point is unclear. Perhaps separate the preferred method of screening and purpose of colonoscopy into two practice points
8. Colorectal cancer screening for Aboriginal and Torres Strait Islander peoples	57	First paragraph: <ul style="list-style-type: none"> • Update sentence to cancer is the leading cause of death for Aboriginal and Torres Strait Islander people and structural barriers that impact the social and cultural determinants of health result in Aboriginal and Torres Strait Islander people experiencing inequitable health outcomes. • Amend sentence to Aboriginal and Torres Strait Islanders people experience inequitable health outcomes and lower life expectancy than non-Indigenous Australians. • Amend sentence to once diagnosed with bowel cancer there are disparities in outcomes for Aboriginal and Torres Strait Islander peoples including: earlier age of cancer onset.
8. Colorectal cancer screening for Aboriginal and Torres Strait Islander peoples	58	Second paragraph: <ul style="list-style-type: none"> • Remove 'current' and add comparative participation rate for non-Indigenous Australians to first sentence. • Add comparative figure for non-Indigenous Australians number-needed-to-colonoscopy (NNC) to make figure for Aboriginal and Torres Strait Islander NNC more meaningful. • Amend sentence to 'lowering the screening start age to 40 or 45 years was predicted to further reduce CRC incidence and CRC mortality by 7–11 and 4–5 percentage points'. • Acknowledging only one consultation with Aboriginal and Torres Strait Islander community in

		South Australia has been conducted on acceptability of lowering the age, therefore this is not a reflection of all Aboriginal and Torres Strait Islander communities and to date there has been no broader consultation.
8. Colorectal cancer screening for Aboriginal and Torres Strait Islander peoples	58	Third paragraph: The recommendation to lower the screening age to 45 contradicts the review of the barriers and facilitators to the NBCSP in reference 115. It is hard to understand how lowering the age will increase participation. Suggest updating as this may be misleading to readers.
8. Colorectal cancer screening for Aboriginal and Torres Strait Islander peoples	58	Fourth paragraph: Provide more information to highlight the inequities and barriers for Aboriginal and Torres Strait Islander people accessing colonoscopies. It is also unclear how lowering the screening age to 45 will increase participation given these barriers.
8.2 Recommendations and practice points	58	Include a recommendation with stronger language relating to inequities associated with Aboriginal and Torres Strait Islander people accessing colonoscopies, particularly in rural and remote areas.
9.1 Considerations in making these recommendations	60	It is not clear how the modelling evaluation and recommendation relates to Aboriginal and Torres Strait Islander people. Other feedback in this section: <ul style="list-style-type: none"> • It is unclear how the earlier starting age is more beneficial than the current screening age. The modelling evaluation summary compares the 'higher' benefits and 'lower' harms of earlier screening strategies (45-74) with a later finishing age (50-79). • It is unclear if the 'higher' benefits and 'lower' colonoscopy burden from an earlier starting age was found at all three modelled levels of participation (40%, 60%, 100%). A participation rate of 40% is realistically the only screening scenario relevant to the current policy context (given the current national participation rate). • Remove the 'with' from 'favourable benefits-and-harms balance, compared with strategies with that stopped screening at a later age'. • Tidy the paragraph (and other relevant sections in both Chapters) by removing all the spelt-out abbreviations of commonly used terms i.e., immunochemical faecal occult blood test (iFOBT), National Bowel Cancer Screening Program (NBCSP) and colorectal cancer (CRC). These are acronyms in previous pages and in the glossary. • The analysis of the screening age range at 45-74 and 40-74 indicates a small increase in lifetime colonoscopy utilisation. Has the impact on colonoscopy services in the public system (as noted on page 39 are at capacity) been considered?
9.3 Harms and benefits-and-burden balance	61	Increasing the age range may deepen existing inequities experienced by Aboriginal and Torres Strait Islander people outweighing the harms and benefits balance.

9.4 Choice and target age range for population screening	62	<p>Explicitly identify actions how health care professionals, professional associations, not for profit organisations and other key stakeholders can ensure equitable participation and ongoing quality improvement initiatives in population screening for colorectal cancer. This is stated throughout the guidelines on multiple occasions, but it is not clear how this translates into practical actions or recommendations.</p> <p>Consider the ethical implications of expanding age range for screening before barriers to participation are addressed i.e., diverting funds to increase the age range versus increasing participation of those currently not engaging.</p>
9.7.2 Resourcing	65	Add additional dot point to include <i>Investment in efforts to promote equitable participation and support CQI initiatives in this regard (as per recommendation on page 62)</i>
9.7.3 Barriers to implementation	66	Expand ' <i>simplifying the method of stool sampling</i> ' to include more information on single samples and, refer reader to 10.1.
10.1 Unresolved issues	67	<p>Add a dot point to include: <i>The ethical implications of expanding age range for screening before barriers to participation for those with inequitable participation rates have been addressed.</i></p> <p>Consider amending the first dot point because the diagnostic performance of iFOBT using one stool sample vs two stool samples could be available by looking at the evidence from international programs and their diagnostic performance.</p>

Family History chapter 2b		
Plain language summary	9	Suggest the purpose of the guideline target a broader audience, not just focus on doctors. For example, primary health care workforce including nurse practitioners, Aboriginal health workers (AHW) and Aboriginal health practitioners (AHP). Change doctors to <i>clinicians</i> to look after people before they get bowel cancer.
Plain language summary – who gets bowel cancer?	9	Suggest using a different term to 'lifestyle factors' i.e., risk factors. Lifestyle factors implies chosen behaviours.
Plain language summary – how to reduce deaths from bowel cancer?	10	Provide evidence why people at risk or with a family history of bowel cancer should consider taking aspirin daily. Consider including a reference to support the evidence.

Plain language summary – who should have regular screening for bowel cancer?	10	Amend sentence to: In Australia people aged 45-74 who have no family history of bowel cancer are considered at average risk of getting bowel cancer, and it is recommended these people take part in population screening, which is offered as part of the National Bowel Cancer Screening Program (NBCSP).
Plain language summary – who should have regular screening for bowel cancer?	10	Amend paragraph to: People with a family history of bowel cancer are recommended to undertake different screening to people who take part in population screening through the National Bowel Cancer Screening Program. They need different screening tests to find bowel cancer early. This will depend on the details of their family history – for example , whether or not someone has had a first degree relative (i.e., mother, father, sister, brother) and/or second degree relative (i.e. grandparent, aunt, uncle) who had bowel cancer and the age they were when they were first diagnosed.
Plain language summary – Where to find information about bowel cancer and bowel cancer treatment?	11	Suggest including references to resources for Aboriginal and Torres Strait Islander people and Culturally and Linguistically Diverse populations
1.3 Target populations	13	Update to people living with disabilities
1.6 Guideline development process	14	Confirm who the Aboriginal and Torres Strait Islander representation in the Working Party refers to. If it is Dr Kate Armstrong, remove reference as it may not accurately reflect contribution or level of involvement in the working party.
1.6 Guideline development process – clinical questions	14	Clarify if the two points are questions. If so, consider restructuring to: Clinical Questions: i) What is the strength of association between family history and colorectal cancer (CRC) risk? ii) What screening strategies should be used for people with a family history based on age, sex, number and relatedness of relatives with CRC?
1.6 Guideline development process – clinical questions	14	Fifth paragraph: Remove duplicated final sentence the choice of recommendation and wording reflects the certainty of evidence.
1.6 Guideline development process – clinical questions	16	Confirm if the final guidelines will be published in September 2023, otherwise remove the month/year and leave as date to be confirmed.

1.7 Scheduled review of these guidelines	17	Suggest including a specific revision date the clinical guidelines i.e., before 2033.												
2. Summary of recommendations	18	Amend sentence to: These people may have no symptoms that might indicate CRC but their family history may indicate increasing risk so that preventative measures or early treatment may be offered to improve health outcomes.												
2. Summary of recommendations	18	<p>Consider including definitions of categories, for example:</p> <p>Category 1 — Those near average risk [edit source]</p> <table border="1" data-bbox="842 483 1841 636"> <thead> <tr> <th>Category</th> <th>Family history</th> <th>Screening recommendation</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>No first- or second-degree relative with colorectal cancer One first-degree relative with colorectal cancer diagnosed at 55 years or older One first-degree and one second-degree with colorectal cancer diagnosed at 55 years or older</td> <td>iFOBT every 2 years from age 50 to age 74</td> </tr> </tbody> </table> <p>Sources: St John et al (1993)^[7], Fuchs et al (1994)^[8], Slattery et al (1994)^[9], Bass et al (2008)^[10], Schoen et al (2015)^[11], Taylor et al (2011)^[1], Lynch et al (2003)^[12], Hall et al (1996)^[13], Leu et al (2008)^[14], Benhamiche-Bouvier et al (2000)^[15], Sandhu et al (2001)^[16], Aitken et al (1996)^[17], Anderson et al (2003)^[18]</p> <p>Note: Relative risk is the ratio of the risk of developing colorectal cancer in a particular exposed group to the average risk in the whole population.</p> <p>Category 2 — Those at moderately increased risk [edit source]</p> <table border="1" data-bbox="842 837 2018 1007"> <thead> <tr> <th>Category</th> <th>Family history</th> <th>Screening recommendation</th> </tr> </thead> <tbody> <tr> <td>2</td> <td>One first-degree relative with colorectal cancer diagnosed under 55 years Two first-degree relatives with colorectal cancer diagnosed at any age One first-degree relative and at least two second-degree relative with colorectal cancer diagnosed at any age</td> <td>iFOBT every 2 years from age 40 to age 49. Colonoscopy every five years from age 50 to age 74.</td> </tr> </tbody> </table> <p>Sources: St John et al (1993)^[7], Fuchs et al (1994)^[8], Slattery et al (1994)^[9], Bass et al (2008)^[10], Schoen et al (2015)^[11], Taylor et al (2011)^[1], Lynch et al (2003)^[12], Hall et al (1996)^[13], Leu et al (2008)^[14], Benhamiche-Bouvier et al (2000)^[15], Sandhu et al (2001)^[16], Aitken et al (1996)^[17], Anderson et al (2003)^[18]</p> <p>Note: Relative risk is the ratio of the risk of developing colorectal cancer in a particular exposed group to the average risk in the whole population.</p>	Category	Family history	Screening recommendation	1	No first- or second-degree relative with colorectal cancer One first-degree relative with colorectal cancer diagnosed at 55 years or older One first-degree and one second-degree with colorectal cancer diagnosed at 55 years or older	iFOBT every 2 years from age 50 to age 74	Category	Family history	Screening recommendation	2	One first-degree relative with colorectal cancer diagnosed under 55 years Two first-degree relatives with colorectal cancer diagnosed at any age One first-degree relative and at least two second-degree relative with colorectal cancer diagnosed at any age	iFOBT every 2 years from age 40 to age 49. Colonoscopy every five years from age 50 to age 74.
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		<p>Category 3 — those at potentially high risk [edit source]</p> <table border="1"> <thead> <tr> <th>Category</th> <th>Family history</th> <th>Screening recommendation</th> </tr> </thead> <tbody> <tr> <td>3</td> <td>At least three first-degree or second-degree relatives with colorectal cancer, with at least one diagnosed under 55 years At least three first-degree relatives with colorectal cancer diagnosed at any age</td> <td>iFOBT every 2 years from age 35 to age 44. Colonoscopy every five years from age 45 to age 74.</td> </tr> </tbody> </table> <p>Sources: St John et al (1993)^[7], Fuchs et al (1994)^[8], Slattery et al (1994)^[9], Bass et al (2008)^[10], Schoen et al (2015)^[11], Taylor et al (2011)^[1], Lynch et al (2003)^[12], Hall et al (1998)^[13], Leu et al (2008)^[14], Benhamiche-Bouvier et al (2000)^[15], Sandhu et al (2001)^[16], Aitken et al (1998)^[17], Anderson et al (2003)^[18]</p> <p>Note: Relative risk is the ratio of the risk of developing colorectal cancer in a particular exposed group to the average risk in the whole population.</p> <p>The following images have been sourced from https://wiki.cancer.org.au/australia/Guidelines:Colorectal_cancer/Screening_based_on_family_history)</p>	Category	Family history	Screening recommendation	3	At least three first-degree or second-degree relatives with colorectal cancer, with at least one diagnosed under 55 years At least three first-degree relatives with colorectal cancer diagnosed at any age	iFOBT every 2 years from age 35 to age 44. Colonoscopy every five years from age 45 to age 74.
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2. Summary of recommendations – risk based on family history of colorectal cancer, Category 1	19	<p>Unclear on where to locate definition of categories of risk in this paper.</p> <p>Every recommendation across both chapters has a strength rating of weak. Addressing and define this rating in both chapters including what are the implications of the weak rating and outline what recommendations could inform future research priorities and directions.</p> <p>Suggest more detail is provided and a reference to support the statement “<i>this excludes anyone known to have a genetic syndrome or related to someone known to have a genetic syndrome.</i>”</p>						
Defining the population with risk based on family history – practice point 4	21	<p>This practice point is also relevant for people who are not connected to their family history (eg: Stolen Generation or people raised in out of home care). Consider providing advice and support for practitioners caring for people in these circumstances. There must be sensitivity given circumstances where people do not have access to family history.</p>						
Defining the population with risk based on family history – practice point 5	21	<p>This practice point is also relevant for people who are not connected to their family history (eg: Stolen Generation or people raised in out of home care). Consider providing advice and support for practitioners caring for people in these circumstances. There must be sensitivity given in circumstances where people do not have access to family history.</p>						
Defining the population with risk based on family history – practice points 10-17	22	<p>Define what is a category 1, 2 or 3 in respective practice points.</p>						

Defining the population with risk based on family history – practice point 13	22	Amend start of sentence to: Category 2 Criteria can be met
3. Risk based on family history of colorectal cancer	24	Amend sentence: These genetic disorders have either an autosomal-dominant mode of transmission (mismatch repair genes and APC) or autosomal-recessive mode of transmission (<i>MUTYH</i>) within families
3.1 Assessing family history and colorectal cancer risk	25	Third paragraph: Are there studies relevant to Aboriginal and Torres Strait Islander people that could be included here. Fifth paragraph: Amend sentence: For the 2023 update, a systematic review of cohort and nested case-control studies since 1 January 2016 .
3.4.1 Included studies	27	If available, include data relevant to Aboriginal and Torres Strait Islander people. If there is a gap in the evidence, this would be good to acknowledge.
3.4.2 Key findings	29	Include the table, and at least the first two columns, at the start of the document.
4.1 Collecting family history from patients	33	Update section to acknowledge cultural factors (for instance, Aboriginal and Torres Strait Islander concepts of “family” may be different to biomedical concepts). Topic may also be associated with trauma and should be approached sensitively. Culturally safe and competent approach to family history is essential.
4.2 Recommendations and practice points – practice point 4	33	Update section to acknowledge cultural factors (for instance, Aboriginal and Torres Strait Islander concepts of ‘family’ may be different to biomedical concepts. Topic may also be associated with trauma and should be approached sensitively. Culturally safe and competent approach to family history is essential.
4.2 Recommendations and practice points – practice point 5	34	Update section to acknowledge that cultural understandings of ‘family’ may vary for Aboriginal and Torres Strait Islander people and should be considered in context of history taking.
6. Further testing and referrals	37	Amend sentence in first paragraph to: This may be hampered by reduced community health literacy and symptom awareness, delayed presentation to primary health care, prolonged wait times for specialist referrals , or limited access to culturally safe colonoscopy services. Consider updating section to include a broader range of barriers and challenges.
7.2 Recommendations and practice points: Category 2 those at moderately increased risk – practice points 16 and 17	40 and 41	Suggest clarifying if people with Category 2 risk of colorectal cancer are required to participate in biennial screening in addition to 5 yearly colonoscopies. If 5 yearly colonoscopies alone are sufficient, state this clearly.

8.1.1 Clinical practice	42	Consider including a reference to cultural considerations in relation to determining family history for Aboriginal and Torres Strait Islander people.
9.2 Evidence limitations	45	If there are no studies relevant to Aboriginal and Torres Strait Islander people, add a note that there is no evidence specific to Aboriginal and Torres Strait Islander people.
9.4 Future research priorities	46	Add that co-designing of future research with Aboriginal and Torres Strait Islander people is a priority